CHAPTER VI

UTILIZATION REVIEW AND CONTROL

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CHAPTER VI
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INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services of providers and by recipients. Federal regulations at 42 CFR §§ 455-456 set forth requirements for detection and investigation of Medicaid fraud and abuse to maintain program integrity and require implementation of a statewide program of utilization control to ensure high quality care as well as the appropriate provision of services. This chapter provides information on utilization review and control requirements handled by the Department of Medical Assistance Services (DMAS).

REVIEW AND EVALUATION OVERVIEW

DMAS routinely conducts utilization review to ensure that the services provided to Medicaid recipients are medically necessary and appropriate and are provided by the appropriate provider. Participating Medicaid providers are responsible for ensuring that requirements such as record documentation for services rendered are met in order to receive payment from DMAS. Under the participation agreement with DMAS, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request.

Providers and recipients are identified for review either from systems generated reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Some provider reviews are initiated on a regular basis to meet federal requirements. DMAS reviews claims for services provided by or resulting from referrals by authorized PCPs in managed care and utilization control programs. In some programs, random sampling may be used to determine areas for on-site reviews. There are also computerized exception reports which look at utilization patterns for providers and recipients. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group. Exception reports for recipients are developed by comparing individual recipient's medical services utilization with those of the recipient peer group. An individual exception profile report is generated for each recipient and provider who exceeds the peer group averages by at least two standard deviations.

To ensure a thorough and fair review, trained professionals employed by DMAS review all cases utilizing available resources, including appropriate consultants, and make on-site reviews of medical records as necessary. Statistical sampling may be used in a review.

The use of statistical sampling is recognized as a valid basis for findings of fact in the context of Medicaid reimbursement. DMAS may utilize a scientific random sample of paid claims for the audit period to calculate any excess payment. When a statistical sample is used, the number and amount of invalid dollars paid in the audit sample are compared to

the total number and amount of dollars paid for the same time period, and the total amount of the overpayment is estimated from this sample. Overpayments may also be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to regulation or statute, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, Medicaid may limit, suspend, or terminate the provider's participation agreement.

Corrective actions for recipients include education on the appropriate use of health care, restriction to designated providers for utilization control, recovery of misspent funds, and referral for further investigation of allegations of fraudulent activities. Loss of Medicaid coverage can result from a conviction of Medicaid fraud.

DMAS UTILIZATION REVIEW RESPONSIBILITIES

Utilization controls are important in ensuring high quality care as well as the appropriate provision of services and the medical necessity for services. Many of the review and control requirements respond to federal and state regulations; all participating Medicaid providers must comply with these utilization control requirements.

Under federal regulations, DMAS must provide for the continuing review and evaluation of the care and services covered by DMAS. This includes the review of the utilization of services rendered by providers to recipients.

DMAS will conduct periodic utilization reviews (either desk or on-site review) of private duty nursing providers. On-site utilization reviews may be unannounced. Medical records of recipients currently receiving private duty nursing services, as well as a sample of closed medical records, may be reviewed. DMAS may also conduct an on-site investigation as a follow-up to any complaints received.

Upon completion of a utilization review, the utilization review analyst(s) will meet with staff members (when on-site) selected by the provider for an exit conference. The exit conference will provide an overview of the findings from the review. When conducting a desk review, the DMAS staff may choose to conduct a telephonic exit conference with the provider’s staff. A DMAS report will be written detailing the findings of the analyst(s) during the utilization review. Based on the review team’s report and recommendations, DMAS may take any corrective action necessary regarding retractions of payment. Actions taken and the level of management involved will be based on the severity of the cited deficiencies which adversely affect the recipients, the quality of services received by the recipients, and utilization control regulations.

If DMAS requests corrective action plans, the private duty nursing provider must submit the plan, within 30 days of the receipt of notification, to the utilization review analyst who conducted the review. Subsequent visits may be made to the provider for the purpose of following up on deficiencies, problems, or complaint investigations or to provide technical assistance.

Services not specifically documented in the recipient's record as having been rendered will be deemed not to have been rendered, and any inappropriate payment may be recovered by DMAS.

DOCUMENTATION REQUIREMENTS: GENERAL

The medical record must contain sufficient information to clearly identify the recipient, to justify the diagnosis(es) and treatment, and to document the results accurately. All medical records must contain documented evidence of the assessment of the needs of the recipient, of an appropriate plan of care, and of the care and services provided; identification data and consent forms; a medical history; a report of physical examinations, if any; observations and progress notes; reports of treatment and clinical findings; monthly supervisory visit reports; and a discharge summary including the final diagnosis(es) and prognosis.

The provider must maintain personal files for each nurse assigned to Medicaid Private Duty Nursing cases which contain current copies of licenses to practice nursing in the Commonwealth, current Cardiopulmonary Resuscitation (CPR) certifications, skills checklists, and documented experience.

The provider must maintain records on all recipients in accordance with accepted professional standards and practice. Records must be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieval and compilation of documentation.

All record documentation must be signed with the initials, last name, and title and be dated with complete dates (month, day, year). A required physician signature for Medicaid purposes may include signatures, written initials, computer entries, or rubber-stamps initialed by the physician. However, these methods do not override other requirements that are not for Medicaid purposes. If a physician chooses to use a rubber stamp on documentation requiring his or her signature, the physician whose signature the stamp represents must ensure that he or she is the only person who has access to the stamp. The physician must initial and completely date all rubber-stamped signatures.

Documentation Required in the Home

The Health Care Coordinator makes periodic home visits to assess the quality and provision of private duty nursing services. This includes review of the following:

- Consistency and Continuity of Care: The degree to which the recipient receives services from nursing staff familiar with the recipient's needs, home environment, and plan of care and receives services continuously according to the plan of care.

- Adherence to the Plan of Care: It is the provider's responsibility to provide the necessary amount and type of services, as reflected in a current plan of care. A plan of care that calls for services to be rendered on a seven-day-a-week basis must be staffed on that basis unless the provider has discussed with the recipient and social support the provider's inability to render care, and the recipient's social support must be able to

provide the coverage in the absence of the usual agency staff. This must be documented in the recipient's file. Holidays are not excepted from the criteria.

- Documentation of Ancillary Services: The degree to which the recipient receives services other than nursing.
  - Identification of all other services that are needed for the individual to be maintained in the home. The documentation shall include, as appropriate, speech therapy, occupational therapy, physical therapy, transportation, physician services, the frequency and amount of service needed, the provider of the service, and the payment source;
  - Contacts for the equipment supplier and respiratory therapist;
  - Documentation of services (as needed and appropriate) including, but not limited to, the school system; Special Supplemental Nutrition Program for Woman, Infants, and Children (WIC); child development clinic services; and Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) services;
  - Identification of the primary care physician in the community who has agreed to manage the medical care of the individual in the community; and
  - Documentation of hospitalizations and medical procedures, both inpatient and outpatient.
- Current Physician Orders for Medical Care: Physician orders must be signed and dated.
- Progress Notes: The degree to which nursing documentation reflects the recipient's status, the technology required, and the skilled nursing care provided.
- Quality of Care: As reported by the recipient or family or observed by the analyst during home visits.
- Health and Safety Needs of the Recipient: Has the provider identified any special needs of the recipient and acted to refer the recipient to service providers to meet those needs?

CRITERIA FOR REIMBURSEMENT

Private duty nursing services that fail to meet Medicaid criteria are not reimbursable. Such non-reimbursable services will be denied upon preauthorization or at the time of DMAS review activities. Medicaid criteria for general reimbursement of Private Duty Nursing services are found throughout the provider manual and include, but are not limited to, the following:

- A signed and dated physician order for the provision of services;
- A plan of care prior to the provision of services, including an assessment and identification of deficits and outcome recipient goals; and

- Documentation available for services rendered and billed.

RECONSIDERATIONS AND APPEALS

Payment to the private duty nursing provider may be denied when the provider has failed to comply with established federal and state regulations or policy guidelines.

The provider has the right to request reconsideration of denials. The request for reconsideration and all supporting documentation must be submitted within 30 days of written notification to:

Supervisor, Waiver Services Unit
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

DMAS will review the documentation submitted and provide the private duty nursing provider with a written response to the request for reconsideration. If the denial is upheld, the provider has the right to appeal the reconsideration decision by requesting an informal fact-finding conference within 30 days of written notification of the reconsideration decision. The provider must submit a detailed statement of the factual and legal basis for each item under appeal. The notice of appeal and supporting documentation must be sent to:

Director, Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If the denial is upheld, the provider has the right to appeal the informal fact finding decision by requesting a formal evidentiary appeal within 30 days of written notification of the informal fact finding decision. The notice of appeal and supporting documentation shall be sent to:

Director, Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. The program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading and adhering to applicable state and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to DMAS is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
900 E. Main Street, 5th Floor
Richmond, Virginia 23219

Recipient Fraud

Allegations regarding issuance of non-entitled benefits or fraud and abuse by non-providers are investigated by the Recipient Audit Unit of DMAS. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries.

If it is determined that non-entitled benefits were issued, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the State Plan, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That

individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Referrals should be made to:

Supervisor, Recipient Audit Unit
Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit in DMAS. Referred recipients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management Program (CMM). (See "Exhibits" at the end of Chapter I for detailed information on the CMM Program.) If CMM enrollment is not indicated, RMU staff may educate recipients on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. An answering machine receives after-hours referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 786-6548
CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the recipient and a brief statement regarding the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.